Academy of PHYSICAL MEDICINE

Transcript

346R- When to Say No

Steven Bruce

What we are discussing today is the challenge of saying no. And I'm going to turn to Claire for her help on this one. Claire, what do you know about the art of saying no. And there's got to be a joke in there somewhere. But let's leave that for now, shall we

Claire Short

And, well, the reason I wanted to bring this topic up was that on Facebook, the other day, somebody was talking about a patient who was very, very complicated. Well, actually, they weren't even a patient at that point. And I'm hoping that if they're a member, that they don't mind me bringing this up. And obviously, I'm not mentioning any names. But it was really interesting that the problem seemed to really escalate. And my sense was that the practitioner was really trying to be a nice person, and really trying to look after somebody who claimed to be in pain.

But who was really behaving quite strangely. And it just made me think that the there is a point at which we need to say no, to protect ourselves to protect other people in the clinic, or to protect the patient themselves. And I just really wanted to throw a throw ideas around about what scenarios do come up for us and what we can say to those patients. So part of the problem with this patient was that they were sending messages, I don't know whether it was through WhatsApp or text messages, but sending messages fairly often and out of work hours.

And was this person was coming up with all sorts of strange reasons why they needed treatment. But they couldn't come into the clinic. So they needed a home visit. So they go that's kind of the starting point for me for today's discussion. I'm not quite sure, Stephen, where you want to take it from there? Well, I hadn't even thought about it until you mentioned this. But so while you were speaking, it did remind me and this is completely the the opposite way round, if you like. It reminded me of some cases, I've looked at that have gone through the Professional Conduct Committee at the G OSC recently, where I think there are two practitioners who were sanctioned in one way or another, for exchanging.

Steven Bruce

Basically, were chatting with patients through private media through WhatsApp or through emails or whatever. And they were trying to build a relationship with a patient, which is a whole different issue. But I suppose the point for me there is it's the separation of business from private life and my whatsapp channel, my whatsapp number is a personal one. I don't Can you have them for businesses? separately? I don't think you can. Can you? Yeah. Okay. So I mean, people should be setting up a business WhatsApp account, which they can then turn off at, whenever business closes in the evening, and not following not get alerts from it.

Claire Short

And one of the great things about WhatsApp, and more and more people are using it now for business, you know, the more more websites and and also trying to say, Yeah, more and more people are allowing patients to, to communicate with them through WhatsApp via their website. But the great thing about WhatsApp is you can mute it. So even I think you have the options to mute for eight hours. And then there's two other options after that. But I think that's really healthy, especially for work because we most of us go into this profession. Because we care because we want to make people better. And our our paucity of research would suggest that we don't go into this for academia, we go into it, because we really, really love it. And we want patients to, to come out of our treatment rooms saying, that's great, I feel amazing. But it does make us then vulnerable to people who want to play games, because we still have such a drive, to rescue and and to fix people. So I think having a rule with yourself about switching off your phone at certain times, I don't think you'll lose that many patients do it simply because people know that at some point, you have to switch off you. And maybe now, now's a good time for the two of us to admit that when we first opened our clinic, we didn't have a closing time. I'll say that again, too. Like we did not have a closing time. So we had one, one massage therapist that sometimes we'd work until nine o'clock at night, which bearing in mind that we lived in the clinic meant that we couldn't eat until after nine o'clock at night because she'd spend a bit of time off. I was having a chat with a patient and then she did let them out and then she tidy her room and tells him to be washed and stuff. And I think it took us about four years before we actually said okay, we know going to save the clinic closes at eight o'clock at night. And strangely, or to our surprise, their massage therapist, he said, Oh, thank goodness for that. That means I don't have to stay for patients who want to stay later.

Steven Bruce

Yeah, we'll probably get some comments from people in due course about their strategies for dealing with this. But I think quite apart from patient handling, you and I certainly have learned the hard way and through mentoring over the years that it's really good business practice to switch off at a given time. And not to feel that you have to run your business 24 hours a day, as small business owners, which most which we all are, you know, we all feel it's our baby and that we've got to attend to it all the time. But actually, it's not healthy psychologically, is it if we, if we're thinking about it, you know, over dinner at night, instead of relaxing with the dog, the children or whatever else. I have had a comment and a long comment in here from Matthew. Matthew says I have a long term male patient who I feel I have to be very careful with. He's a fit alpha male type, single rugby playing, but acutely sensitive to anything he can interpret as criticism. He tries to project tough

masculinity, but he's actually quite fragile and oversensitive emotionally. He's 57 acts like he's 30. At our last treatment, he said he couldn't understand why I couldn't just click him like I used to. I took the opportunity to explain in detail that if nothing else, I was required by the regulator to provide treatment appropriate to his condition and circumstances. He replied that he didn't want an explanation that sounded so negative. And to just do what he asked for, of course, I persisted and said that I had to make sure that his consent for treatment was fully informed. And as it got, I just moved this, again, is confirmed was fully informed. At that point, he dropped his head and half stood in an awkward posture saying he was trying to decide whether to leave without treatment. However, I did continue to treat him within the restrictions I'd outlined, but it was somewhat awkward. He said things like, you just don't want to lose, do you? I'd already had concerns regarding him bordering on a safeguarding issue over something he told me, I now feel that, dear,

sorry, I keep losing the I was encouraged by the regulatory to show these consent.

So you don't want to lose, I now feel I don't want to treat him as we can't reach a common understanding as to the outcomes we expect? And, yes, this is something that you sort of ran by me before we started clear, isn't it? That whole business of patients trying to dictate treatment, and the ones who come in saying I want to be clicked. And the ones who come in and saying no, you just need to adjust my neck or not adjusted or whatever else. And it's a difficult one when they start getting too authoritative.

Claire Short

It's also, I think it's quite hard as well, because all of us know that we like to be treated in a certain way. There are times when I could go to Robin and say, All I need is to be crunched. And I'm absolutely certain that I know my body really well, please, could you do that? Like, it's another time I could go and say, I just need somebody to unravel what's going on in my neck and my shoulders. So I think a lot of it depends on the type of person you're dealing with, and how they approach it. You know, if I stood in front of Robin and said, yeah, just click T four. And he'd probably say, Here's the door clear. Or perhaps try and justify why different sorts of treatment was was a better idea. So I think it does, does really depend on the patient. But we do have to acknowledge that if a patient has seen somebody else for 12 years, I'm not saying they saw the patient for weekly sessions or anything, but over a period of time, and they just know what works for them. Who are we to say actually, I'm afraid that's not what works for you.

Steven Bruce

We have to be quite careful in refusing treatment to patients. So don't we?

Claire Short

Yes, and I think that was one of the things that was discussed in in this Facebook post was that it is okay, is fine to say actually, I don't think I'm the right person for you. And that's one of the things I thought would be interesting to cover today is how, how do other people phrase that and say,

Actually, this isn't going to work? And and help the patient move on to somebody else? Or go somewhere go and do something different? Excuse me?

Steven Bruce

Yeah, sorry. We've got you on the show today, Claire, and you are still recovering from COVID on you, which is one of those nasty bouts of COVID. Well, we'll put we'll put up with your coughing if you carry on contributing, it's good. The other thing where I was going with this is that I've known practitioners say that, you know, it's really difficult to legally for us to refuse treatment. But of course, you made the point there. We can refuse treatment. It's perfectly legitimate provided we're doing it for legitimate reason. And that we're not doing it because of any sort of sort of prejudice or on our part. And in particular, that brings up the business of protective characteristics which include age, disability, gender reassignment, marriage or civil but I'm reading off a list here as you can do. Marriage, civil partnership, pregnancy, maternity, race, religion, sex and sexual orientation. Those are the list. That's the list of specific protected characteristics. And I'm thinking about maybe the woman who works as a sole practitioner saying to a man, I'm sorry, I can't, I can't see you. And she's doing that on the basis of probably all of his sex because she's vulnerable in a clinic by herself. I know late at night, and she's worried about people coming in if she's on her own. But it is perfectly okay to do that. It is it is legally okay to do that.

Claire Short

Stephen Robins got his hand up. I think he's gonna refuse to treat me.

Steven Bruce

Robin, please tell us what you think.

Robin Moody

I was thinking if Claire told me to treat T for I do it because I'm frightened. No, I wouldn't I I think it depends on the context of the patient you're dealing with, doesn't it? And some patients where if they, if I feel like they're starting to try and dictate. And if I feel that I know the patient well enough, you can, at times be quite light hearted about it. I have said to a patient this morning that was was getting a little bit sort of, is there one here? Is there one here? And can you do that? Can you do that? And I said, I said should we play a game where you're the patient, and I'm the practitioner. But that's a patient that I know well. And I know that I can be a little bit cheeky in my response to my answer to it. Other ones? Yeah, I think you've got to, you've got to be a little bit more careful. And I spend a lot of time and I try and make sure that my rhetoric with all of my patients is reminding them of what it is we're trying to achieve what it is that I can treat, and how we can treat mobility and function that we can't cure things. And what we are treating is a heavy mix of wear and tear that we're with the best will in the world. It's wear and tear, it's life's trophies. And then there's the component that is soft tissue irritation or injury that needs time to heal. And that's a Moveable Feast. It's an equation that I put to them. And I say we've got wear and tear. We've got soft tissue injury rotation, and we've got mechanical restriction that we can influence and that's the bit that

we're treating. And so I try and thread that through everything that I do with the majority of my patients with with sort of variation depending on circumstance. Yeah.

Claire Short

Robin, could you just say though, you said something magical there second ago. Was it jokes no

Robin Moody

trophies, life's little trophies. See,

Claire Short

that's why that's exactly why I wanted to do this show was because I wanted everybody to have some some new phrases and new ideas of words that you can put together that might help you go through the process of controlling a patient who's out of control in whatever way that's really nice. I like that. Nice.

Steven Bruce

Well, I've got a couple for you that have come in from Gareth if you like Claire. Gareth says he's had a few people asking for the Y strap or the ring dinger adjustments. I have no idea of what those are. Gareth please. You should be on teams you should be on cameras so that we can talk to you about what the hell that means. The wide strap and the Ring ding or adjustments. Maybe we can build those into our vocabulary? Yes, Robin?

Robin Moody

Yeah, I can answer that I've had a lot of that. There's a particular character on YouTube who who likes the if you'll pardon the pun the clickbait there's a couple of them actually, I don't I don't personally think they're doing our profession any favours.

Steven Bruce

So again, but they are chiropractors are osteopath so people are putting these up? Yes.

Robin Moody

Right. Yeah. The why strap. I think it's Dr. Joseph Shapiro is the guidance is that's why he's on Facebook anyway, on YouTube. And if the white strap is it's a it's an apparatus that goes around chin and the occiput and then it's attached to a water ski handle. And it's it's billed as an axial decompression technique. But he will bring patients 1218 inches up the couch with a high velocity manipulation. On their neck. I've seen him put a video up where he was treating a tetraplegic patient

with the same technique and it's revolting. Frankly, it's not a technique that I will let anybody near me with I tend to respond in not dissimilar terms. I'm fairly robust about it. And, and my response would be, this is not the clinic for you, if that's the adjustment that you want. However, if you want to have a look at what I do, I'm willing to help or try and help

Steven Bruce

you. Yeah, it's, it's hard to imagine that what you've described is safe. And I think now that you say it, I think I've seen some I have seen those videos on YouTube myself. But whether it's whether it's professional to say that that is an unsafe technique, I don't know, because we're not supposed to comment adversely about our fellow healthcare professionals.

Robin Moody

Well, I mean, I can't evidence my statement, but there are there are surgeons, orthopaedic surgeons reacting to those videos. For me, I don't like it. I think it looks like a recipe for Vbi. Personally, yes. But I can't evidence that. So yeah, if he's got better evidence than me, then for all power to him. Yeah.

Steven Bruce

Sorry, Claire. Yes.

Claire Short

Is something else in in that that I thought was really interesting. And that was, it's a bit of a throwaway line of Robins. But his response to a patient who might ask for that is, would you like to see what I am able to do, the techniques that I use, and I think that's another gem, because you're giving the patient the choice to walk away. And I think the next thing, really important thing that can happen in that situation is that you stop talking, which we will know I'm not very good at. So by leaving a pause, you allow yourself the time to think if this patient says anything, that would suggest that they don't want to have treatment, I am going to allow them to leave, instead of encouraging them to stay for whatever reasons. Normally, that reason, of course, is that we want to fix them. But if if you've given that patient the choice, and then you stepped back and allowed them to choose and giving them space to make that decision, if they then say actually, this isn't what I want, you have just created it at a magical moment, because they can walk away and save you the hassle of having to deal with somebody who's really, really difficult. And something you said earlier on Steve, and that was very similar about the patient who can choose not to have the treatment. And if they don't want it, you know, we should be big enough and clever enough to not encourage them to enter let them walk out the door.

Steven Bruce

Here's an example that I have spoken about this on a couple of occasions in the past, but in the context of fitness to practice. It was one of the first cases that I looked I went and attended the

Professional Conduct Committee at the generosity of other council Council. It was a female osteopath was under scrutiny at the time. And I'm not going to name her because I don't want to embarrass her in any way. But she had had a patient come to her for treatment for an ankle and he wanted a particular type of treatment. But she had said, I think this treatment will be better for you. And she convinced him to go along with that. And he seemed happy with the treatment she recommended was ultrasound. She was doing an MSc in ultrasound. So she knew what she was talking about. And he subsequently he came back for, I think, for a second treatment. And he'd seemed lovely about the whole thing. But he then complained to the general osteopathic council that she had given him treatment that wasn't evidence based. She hadn't explained it properly. So if you hadn't got proper consent from him, you know, he, in my opinion, he knew all the right boxes to tick in a complaint to mean that they had to take it seriously. And the worst part about it, which is again, perhaps outside the scope of what we're talking about here is that the General Counsel Professional Conduct Committee, not the general counsel, because they are separate the personal conduct committee, quite bizarrely decided that she was guilty. Both the prosecuting and the defending barristers had said this isn't going to go anywhere. This is a cut and dried, nothing to art no case to answer. But they found a guilty and it took I think two years before it went to the UK high court, the court of appeal. And it was overturned by the Court of Appeal and a very clear judgement came back saying you really should never have gone down this route. This is ridiculous. And the reason I mentioned that is because in our desire to be what Robin described the really helpful practitioner and to but at the same time decline what the customer the patient wants us to do and do our own treatment. We are perhaps creating a situation where they might want to make some sort of complaint about that and we need to be careful. Turning to the questions from the audience, Kim has said Do you know anything about transactional analysis, which I confess I don't anybody No, maybe someone can come back to a supplier men transactional analysis, it sounds like a useful thing to do if it means what I suspect suppose, which is reflecting on the way you've handled situations and adjusting accordingly. So Kim, if you've got more information, that'd be great. Lorna says she had a 90 year old osteoporotic lady refused any treatment because I wouldn't crack her neck like someone had done 40 years ago. Thankfully, her son was with her and fully agreed understood my reasoning. Yeah. And I think that's perfectly reasonable, isn't it?

Claire Short

I'd say so Robins got his hand up, by the way. Yes, Robin.

Robin Moody

Sorry, Stephen. It was just it was a follow up to what you said. You were saying earlier on about. If we are not providing or we decide we're not going to provide treatment? My understanding is that we are we have a certain duty is to try and help the patient find a more appropriate therapist, is that correct?

Steven Bruce

I think it's regarded as good practice. But I haven't been able to find it lead down anywhere in the osteopathic practice standards or in the chiropractic code. So it's not something we're directed to do. Nor are we directed that we must provide treatment, of course, we're simply told to treat

everybody equally. And I think there are any number of reasons why we might say to someone, I'm not the right person for you. Or I can't, I can't provide that treatment for whatever reason. And in this osteoporotic case, there are very good reasons not to do high velocity thrust on a neck, I am sure everyone would agree. So, yeah, I like you. I've always thought that if you are going to turn some away, I've been told it's sort of, it's the gentle way of doing it to saying, Look, I'm not the right person for you, you might want to go and try. So and So down the road, whatever else?

Robin Moody

Yeah. Yeah, I mean, I had a similar, long, long time ago, now I had a chap come in to see me who I'd done his initial assessment, or the initial chat, taking his medical history was talking to him about examination and treatment, sort of par for the course and transpired that he had had. Cranial osteopathy previously, didn't realise that there was a difference between cranial osteopathy and what I practice. And so when I went to wash my hands and came back, he quizzed me further. And I explained a little bit more. And ultimately, I said, Look, I'm not going to make you have any treatment. So if you feel like this isn't what you want, if you want to go away and have a think about it, and come back, or if you just think that and he said, I just I don't I don't think it's what I'm after. And I said, well, well, then fine. And actually I often no fee, no, sorry, that that wasn't made clear to you coming into into the treatment room, or when you found me. And actually he insisted on paying half a fee, which was I thought was rather nice of him. And we shook hands and we parted his friends. And I think that was quite a yes. A nice little example of getting the communication, right. And having that like, like Claire was saying, having the ability to just say it's okay, you don't have to have anything that you don't want happen, because it's another little thing that I make sure I do on a regular basis is remind patients that, that their informed consent is theirs to withdraw. And if at some point they decide you're not I don't like that anymore. Let me know. Absolutely, let me know. And we will have a look and see what alternatives we can we can use.

Steven Bruce

Yeah, and I think, as always, it's worth re emphasising that business. Consent is a continuing process. Consent at the beginning of treatment doesn't mean even that you've still got it halfway through, you have to just keep reminding the patient that they have that option to withdraw consent, particularly if it's a technique they've not experienced before. And I'm going to bang on about something I often bang on about and it's recording everything in the notes. When a patient in the situation you've described says no, it's not for me and voluntarily goes elsewhere and offers to pay half the fee. I don't think you're likely to have any problems. But in the case of the Osteopath, I mentioned who she had provided different treatments to or in a case where you say I'm not the right person for you. I think you've got to be meticulous in recording those reasons in your notes. Because if that patient complains, you've got to be able to say, this is what happened. And as you know, as we often say, if it's not in the notes and it will be thought of as not having happened. Absolutely. John has sent in another long comment. Sorry. Sorry, Martin. You put your hand up. I beg your pardon. Yeah.

Martin Matthews

Yeah, hi. I am so I saw I saw somebody this morning a dentist and he'd been to see a Another physical therapist, not an osteopath, who had but somebody who's well versed in manipulation who manipulated his neck in a really very physical manner and gave him tinnitus, which is so bad now he can't work. So he's been off work for a month. And so the person, the therapist responsible, I think, is responsible for this tinnitus. And so I'm thinking, Well, I'm certainly not going to do any manipulation to this guy's neck, because I don't want to end up in front of the GEOSS. Again. And so I said, Well, you know, what else? Have you tried? I've tried acupuncture. Did that work? No, it didn't work. Did you see a proper acupuncturist? Yes. So I'm thinking well, so I said to her, what would you like me to do? Because that's kind of what I do. And he said, Well, I don't know, you know, have a look and see what you think. So I had a look. And I thought I thought, but really, I feel that my hands are fairly tied as to how to treat this guy. But going back. So my inclination is to say, you need to find some other form of treatment. But I'm going back to what you were saying earlier in what Robin was saying, I don't know who to suggest, to refer this guy to because I always thought that it was kind of our duty to refer a patient on to somebody else if you can treat them yourself. So I don't know who to send into. Plus, also, going back to what Robin said, I always thought if you decided that really you couldn't help somebody, so you didn't charge them a fee that you weren't insured. So I'm wondering if you can help with this? Or anybody, Steve, and anybody out there? Are you insured if you don't charge a fee? And who what do you do? If you don't know who to refer a patient on to if you can't help yourself? Yeah,

Steven Bruce

well, simple answer is you are insured. If you've made if you've got an appointment with a patient, and it's a consultation, you are insured, regardless of whether you charge them or not. In terms of referring people on I guess, nobody can nobody can insist that we know all the treatment options that are out there, I guess the default option is I think you should go back to your GP and find out what the conventional services can offer, you might not be the best option for the preferred option for many of us. But it's certainly one thing that occurs to me. And if other people have got different opinions, I'd love to hear from them. This

Martin Matthews

guy had it this dentist, you know, so I think you always have to be really careful when you're dealing with other practitioners and medical practitioners. And this dentist had had his neck manipulated in quite a violent fashion without consent. So the person responsible, just got up behind him and given this huge crack to his neck, which was created the symptoms. And you know, given what I've had to put up with in the last year, which you're very familiar with that, you know, just terrifies me really the here we go again, you know, someone's going to make a complaint. I don't think this dentist will but he's, he might change his mind about it. But it just feels to me, I don't want to be anywhere near anybody who could possibly make another complaint against me. Yeah,

Steven Bruce

you might not be familiar, but Martin was on my show some time ago, had a complaint from a patient and and he was exonerated by the professional conduct by the investigating committee, and so hasn't suffered any sanction. But the process took a long, long time, for which both he and I feel

there was little justification. But that all that time, he said to us in the past, and he couldn't think of anything else. Every time you seeing a patient, all he's thinking about is that complaint going through the process me really is a stressful process. And Matthews actually asked if you can see the appeal court ruling on that case that I described earlier on, which I thought was a model of clarity was an absolutely brilliant piece of writing by a judge. And if I can dig it out from my records because it was quite some time ago, then I will happily share it in a follow up email. Now John has said when I was starting out in practice, I had a lady who wanted me to treat her for neck and shoulder pain. Having taken her details and proceeded to inform what my examination would involve. She then went on to tell me how I should examine her and come to her diagnosis, no matter what my training involved, no matter no matter what I said to reassure her that my skills in evaluating and biomechanics were adequate. She insisted that I look in I look to assess her her way. As she was in the right. I quickly realised that no matter what I did, it wouldn't be welcomed treatment. I therefore informed her that I didn't think that I was the right person to treat her and thankfully, she said I agree. And I didn't treat her only hope that the person who she did see for treatment had better outcomes. That's quite an extreme version, isn't it? Claire have a patient trying to take control. And and I think that if you know if you were to refuse to treat that particular patient, no right thinking person could contradict you because you can't you cannot be driven by a patient directly, not only what you do, but how you work out what to do.

Claire Short

Even massage therapists are taught from day one of training you do not let the patient dictate the treatment. So, I think us we with our medical training, really we stand in good stead for saying this isn't right. And Martin's sorry, Robbins goes hand up, Robin.

Robin Moody

That was I was just thinking that there's a there's a potentially useful and interesting juxtaposition there as well to the, the Dr. Google patient who gets their own diagnosis, diagnosis, right. In terms of, again, communicating and saying, Okay, I hear you, I understand what you are thinking and where you're coming from, let me do my examination and see which conclusions we come to. And if your conclusions agree, I, it can be quite empowering for the patient, quite reassuring for the patient. And then, of course, you've got the if they've got it completely wrong, because how many patients come in and tell you they've got sciatica in their left arm. And you have to sort of quite calmly explain to them that that's not entirely possible, but you understand what they're describing to you. And let's go in there and get you a more detailed answer as to what we think might be happening. See, I think you can use those things a little bit to your advantage, whilst at the same time being a little bit careful with it. Yeah, yeah.

Claire Short

Even we had a classic example of that the other day, didn't we, friend of ours slipped over and fractured her back in three places, she was told. And when, when she came out of hospital, she was she had no surgery, and was told she had to stay still for a week, and then kind of take things easy for a month. So Stephen and I are thinking this can't be a particularly serious fracture, or series of

fractures. But it's fascinating that she said, when when we went to see her, she said, actually, it's the sciatica that's really hurting and pointed to SI joint. So

Steven Bruce

she didn't say, easy, because she didn't take the back fracture seriously, did she

Claire Short

wish she thought they had missed a fracture, and that actually, she had fractured her pelvis. But she had, she had given the the pain, the wrong name, because there was no sciatica involved at all, it was very clearly pain around the sacroiliac joint. And the front three fractures were around the DL, it was L one, two, and three. And she had absolutely no pain there at all. So just going back to what you're saying about Dr. Google Robin, you know, when patients come in, you really do have to fight your way through the information that they've acquired from the internet these days, don't you?

Robin Moody

Yeah, very much. So it's led me on to another thought in terms of whether it quite applies to this. I had a patient in a couple of weeks ago, who I think might be my monster in law's long lost cousin, because she did the same thing, which was to describe the sight of her injury, as in the garden, in absolutely minut detail. And it was genuinely 20 minutes, that she was in the room before I had any idea about why she was there and what she had her and how she had herself. But I didn't know where all the futures were, and where the Daffodil bed was, and how tall the step was and what it was made of. And it could have all been condensed into half a sentence. I really struggle with intervening when I have somebody who's sort of off on one and said, right, come here to Mitch, where does it hurt? Some sometimes I kind of have to do again, I can be a bit cheeky, I suppose. But I kind of have to try and play into a little bit comedic, and try and beat sort of gently into that one. But you get the patient that doesn't and just keeps going. And I don't know how to do that. So ideas on that would be useful.

Claire Short

I really did it that because because I'm not very nice, because you're frightening. Yeah, we will stop that. Yeah. So I just say stop, stop, stop. Now, we have approximately 15 minutes to get this all of these details onto a piece of paper so that I can treat you I might be exaggerating on the time but you know, I try and condense it for the my my stuckness let's get to the nitty gritty of it. Show me where the pain is and what Once I've got them to stand up and point to where the pain is, normally I can control they're talking. The only downside of doing what I do is that you then have to spend the whole of the rest of the appointment trying to get them back on side and love you again. There's definitely a kind of war osteopath shouted at me moment.

Steven Bruce

But yeah, I'm going to re emphasise Claire, I'm going to re emphasise exactly what I just said a moment ago, if you've had to do something like that, put it in your bloody notes, because one of them one day will complain and say osteopath was rude to me. This was poor patient handling. And you need to be able to look back and say, yeah, they talked for 15 minutes. And all we've got to was the garden gate at this stage. You know?

Claire Short

That's a really good point. Really good point. And actually, the whole business of writing things down came up on our discussion about case notes on the Jane discussion forum recently, Jane being the diary that we use, and somebody asked, whether, when she was a counsellor, not a hands on practitioner, but she said, If I do a free consultation, to see whether our relationship is right to continue with treatment, do I just delete the patient afterwards, if the patient decides not to come back, and my gut instinct with that was you document everything that's happened in that appointment, because you're, you're responsible for that time with that person.

Steven Bruce

Yeah, and just as Robin asked, whether you're insured for a free employee a free appointment, you've still you need to document it as an appointment. It's they go and complain, or if anything happens, you've got to have those notes. And we've got little time left, and we've got some more things coming in. One of the things I did want to say, based on this constant thing that's coming up about me bringing up complaints is we are required to have a complaints process in place. And so somewhere, patients are required, you're required to provide patients with guidance on how they make a complaint about you or your practice. And whether that should be to the clinic director or whether it should be the generosity practical chiropractic Council, and people should make sure that is in place because they'll be held responsible if it's not clear. One of the things you spoke to me the other day about was people being rude on the on the telephone to reception staff or to practitioners themselves. And is that I mean, that's something that you've got a policy with, what do you do? I think the words you used in the message to me, you're not once you'd use to a patient?

Claire Short

Really, what did I say? I wouldn't possibly have said anything unpleasant? Yeah, I think I think is what we were saying earlier on. It's so individual, how you deal with people when they're they're complaining? We've done we have done some training with an HR person on, you know, how to allow the person complaining to vent, what's going on for them and to get it off their chest, and to give them the space to do the talking, which is really hard when they're attacking you. But it does it definitely diffuses the situation. But I think it's it's really tough when it's somebody who works in your clinic that's being attacked. And you have a sense of responsibility for the people who work there don't use those much harder. Well,

Steven Bruce

I don't know if we do it at the clinic, possibly we don't certainly here at APM all of our telephone calls are recorded. And just so that before people harangue me about that, you do not have to tell people that your telephone calls are being recorded unless you are using them to share the information with people outside your organisation. So all those bloody annoying messages saying that telephone calls will be recorded for training and monitoring purposes. They're unnecessary. If all you're doing is looking back to see you know, how you're handling your your calls, and so on how you can record calls. And it'd be quite a useful one because if you've got a call where someone's being rude to the staff on the phone, and let's say you ever ended up having to answer for your actions, you could say no, but I listened back to the call and it was definitely offensive. You might then be required to produce the evidence, but that's fine. So the law requires you to produce it you can't refuse. Anita says I had a patient who insisted on an MRI referral, they saw a GP who initially refused. She had low back pain it was L for five facets which I managed to resolve and then I gave her exercises where prevention information patient rang asking for an MRI I managed to postpone to Monday. Then when I called them he was stroppy retelling me I had got an MRI, that they had got an MRI through the NHS. I didn't feel she needed a scan. I guess that's going to be more and more common these days, isn't it? Everybody thinks they need an MRI for everything. And they also seem to think that they're easy to get quick to get and possibly cheaper than they are. I suppose most most people watching this will be saying well you know I can't really Are you directly for an MRI? You'd have to pay privately? And a lot of people say, Well, I'm not going to do that. And unless I think it's necessary, what about nuclear? Microphone, please.

Claire Short

Sorry. Yeah, it's a difficult one, isn't it? When I did some training with the MRI team in our local hospital, they were saying that a huge proportion of the patients, they scan their scanning to reassure the patient, and they were really aware of this, that it wasn't to diagnose something dangerous, it really was to make the patient feel safe again. And they just accepted that that's how it was. And that made me much more relaxed about feeling that I could say to a GP, the patient's concern is rather than my concern, so kind of making it the patient's request, but equally saying that I wasn't unhappy about them going for a scan. And I appreciate that possibly wasting lots of people's money and time. When

Steven Bruce

I suppose if they want to go for a private scan, it doesn't matter, you can refer them and say, This is what we want to rule out. And if the patient wants to play, if you've explained to the patient, you don't think it's necessary, they're still happy to pay, then it's their visit, I've got a really important one that's coming from Laura here, which I'd like to read. She doesn't know what the right thing is to do. She sees a few people who don't speak English. They usually bring a family member as their translator, but recently, that was their 16 year old daughter who didn't understand the importance of medical history, etc. Do you treat unsure whether your medical history is complete? Or do you refuse treatment running the risk of being accused, for example, of refusing to treat on the basis of race, which is a protected characteristic of a thought on that? Well, having

Claire Short

having been in situations quite a lot of times myself, and I did voluntary work for the Medical Foundation for victims of torture. And when we lived in London, and I had a very similar situation in that normally, I would have an interpreter in the room with my patients, but sometimes there wasn't one available. And so one of the children would be interpreting. And it's just really, really hard. And I hate No, I don't hate going back to the the phrase that everyone despises these days, but I think is really osteopathic. It does depend. And I think it really, it really depends on how you feel the information has come across how much information you've got from that patient, can you change the way that you're asking the question? So I don't know if you remember, but Stephen and I did some rather silly training about doing video appointments, when we're in the middle of COVID. And I was in my dressing gown with dirty socks behind the on the washing line. And Steven got his nose here on the screen. To be quick was to really just help people understand that there are different ways of asking the question. And it's just a matter of finding those ways.

Steven Bruce

Yeah, and following on from it very quickly, of course, you've got to be sure that you have got valid consent from that patient. And if the interpretation if you're not sure of the interpretation, that is always a Get Out of Jail Free card because you say that I just don't know that they understood and you can't give consent if you don't understand. Cara, you made an interesting point about suggesting that you might need a fresh set of eyes on an issue for Pete if you want to move a patient on and Claire she likes your phrase, I'm not the right kind of person for you because it's quite a kind one. So that's all we got time for them in 380 people watching so I'm very pleased about that. Hope you've all got some value from that. And as always, I hope you found that useful.